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SHRM » Publications » HR Magazine » Editorial Content » 2010 » December 2010 » Unexpected Boost for Consumer-Directed Health Plans

Unexpected Boost for Consumer-Directed Health Plans
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Health economics professor Stephen T. Parente explains why reform and health savings accounts are a natural fit.

12/1/2010 Interview by Stephen Miller



Stephen T. Parente, Ph.D., is the Minnesota Insurance Industry Professor of Health Finance at the University of Minnesota's Carlson School of Management, and director of the university's Medical Industry Leadership Institute. He has been the school's principal investigator for funded studies on consumer-directed health plans since 2002. HR Magazine recently spoke with Dr. Parente about health care reform and consumer-directed health plans. These plans typically combine high-deductible, lower-premium insurance with health savings accounts or health reimbursement arrangements. The former are funded with pretax dollars by the employer and are portable: Employees can take these accounts with them on termination. Health reimbursement arrangements are funded solely by the employer and are not portable.

Do you view the health care reform law as positive or negative for employers?

The reform legislation represents the biggest change to the U.S. health care system since the Employee Retirement Income Security Act was passed in 1974. The change has positive and negative features. Among the negatives, a number of expanded coverage requirements are going to be disruptive for employers and their balance sheets, particularly coming out of a long recession. New reporting burdens may be costly and done in ways that are not efficient. On the plus side, the reform encourages employers to think more systematically and strategically about the health benefits they're providing.

According to the Kaiser Family Foundation, consumer-directed health plans (CDHPs) provided coverage for roughly 13 percent of all insured U.S. employees in 2010, up from 8 percent in 2009. Is the future of employer-provided health coverage with consumer-directed plans, given that preferred provider organizations (PPOs) still enroll 58 percent of covered workers?

There will be continuing growth in the CDHP market, although these plans may not eclipse PPOs for at least five to 10 years. Implementation of the Patient Protection and Affordable Care Act will accelerate adoption of CDHPs. I find that ironic because reform proponents were not fans of the design. But year-over-year premium increases for CDHPs are generally less than for PPOs, and mandates within the legislation will lead employers to favor reduced-premium plans. For instance, starting in 2018, a 40 percent excise tax, the so called "Cadillac tax," will be imposed on high-value health plans—those with an "aggregate value" exceeding \$10,200 per individual and \$27,500 per family. CDHPs may be one of the few ways to avoid the Cadillac tax.

Do consumer-directed plans help limit overuse of health care, such as unnecessary tests and expensive therapies when there are less-costly and equally effective options?

My research has shown that health savings accounts (HSAs) and health reimbursement arrangements (HRAs) curtail unneeded overuse of medical services by giving patients a tangible incentive to talk with their doctors about treatment options and their likely benefits and costs. But it depends on the benefit design, such as whether the total out-of-pocket spending before coverage is provided with no cost sharing. If, for instance, the plan is overly generous, with maximum out-of-pocket spending limited to \$1,000 for family coverage, it probably won't save money because consumers won't have enough incentive to be price-sensitive.

What do you view as effective deductibles and out-of-pocket maximums to limit overutilization of health services?

Effective total annual deductibles are probably around \$3,000 to \$4,000 for individuals, and for a family plan closer to \$7,000 to \$8,000. To keep health cost inflation down to a percentage point above general inflation, that's what it's going to take to engage the consumer sufficiently to make a difference. For those with chronic illness, such as diabetes, such deductibles seem too high. Those consumers should be targeted for exemptions and offered wellness or disease management programs that work with them on changing behaviors and better managing their conditions. Insurers need to address chronic conditions that are not behavior-related in separate vehicles, such as high-risk pools.

Under the reform law, limits on deductibles go into effect in 2014. These limits will be \$2,000 per individual and \$4,000 per family, but only for small-group-market plans. What does that mean?

Pushing the deductible threshold too low can defeat the purpose of setting reasonable premiums as well as getting employees to be cost-conscious. It's unfortunate that the small-group market has been singled out for these deductible limits. Employers that have small profit margins have traditionally offered high-deductible plans. They may do the math and find they can no longer afford to offer coverage. It's going to be tricky for them, because paying the penalties under the "play or pay" provisions could kill a small business. As a result, unless this limit is altered or repealed, we may see more self-funding—even by employers at very small levels, despite the added risk they'd bear.

Will the requirement to cover preventive services on a first-dollar basis reduce the effectiveness of CDHPs in curtailing overutilization?

No. Many CDHPs already meet this requirement. The only factor that might derail their ability to reduce overutilization is if the definition of preventive services is broadly expanded. That could be a concern—but it would affect all other health plan designs as well.

Some employers prefer HRAs because the funds revert to them when employees leave. Many analysts prefer HSAs, saying they give employees "skin in the game" because employees get to keep money they don't spend. What's your view?

From my research, I definitely see more effect on consumers' behavior when they have HSAs. When employers give consumers "skin in the game," the consumer might actually consume less. With HSAs, on the employer's balance sheet it's going to be more expensive upfront to put money in an account that's "owned" by employees. In the long run, in terms of total medical spending, the actual output might lead to a broader savings beyond what gets recovered in an unused HRA.

Some employers offer a consumer-directed plan as the sole option to achieve behavioral change and cost savings. Others provide a choice of CDHP or traditional PPO-type plans to "make the medicine go down more easily." What strategy do you see as more effective?

There is a value to saying "everyone into the pool" by providing only a consumer-directed plan. It may be a shock at first, but it helps employees understand the shift to consumerism as a strategy for curtailing unnecessary spending and controlling costs while providing protection when needed. Again, for those with chronic conditions, there are ways to directly support them that make more sense economically than through an open PPO design.

How will the dollar limits on flexible spending accounts—capping contributions at \$2,500 per year beginning in 2013—impact adoption and use of HSAs?

It will likely increase their appeal. They have a higher contribution limit and are not subject to the use-it-or-lose-it rule at the end of each year.

The interviewer is editor/manager of the SHRM Online Benefits Discipline, www.shrm.org/rewards.



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